Complete Summary

GUIDELINE TITLE

Neurogenic conditions. In: Guidelines on chronic pelvic pain.

BIBLIOGRAPHIC SOURCE(S)

Neurogenic conditions. In: Fall M, Baranowski AP, Elneil S, Engeler D, Hughes J, Messelink EJ, Oberpenning F, Williams AC. Guidelines on chronic pelvic pain. Arnhem, The Netherlands: European Association of Urology (EAU); 2008 Mar. p. 73-4. [3 references]

GUIDELINE STATUS

This is the current release of the guideline.

COMPLETE SUMMARY CONTENT

SCOPE

DISEASE/CONDITION(S)

Pudendal nerve entrapment or other neurogenic conditions such as changes of denervation and re-innervation causing perineal pain

GUIDELINE CATEGORY

Diagnosis
Evaluation

CLINICAL SPECIALTY

Neurology
Obstetrics and Gynecology
Urology

INTENDED USERS

Physicians

GUIDELINE OBJECTIVE(S)

- To help urologists in the clinical decisions they make every day
- To provide access to the best contemporaneous consensus view on the most appropriate management currently available

TARGET POPULATION

Patients with chronic pelvic pain arising from pudendal nerve entrapment or other neurophysiological problem

INTERVENTIONS AND PRACTICES CONSIDERED

Diagnosis/Evaluation

1. Exclusion of local pelvic pathology/structural cause
    - Magnetic resonance imaging (MRI)
2. Evaluation of pudendal nerve entrapment
    - Evaluation of pain: location, quality, characteristics, alleviating and contributing factors
    - Examination of the perineum
    - Neurophysiological examination
    - Sacral reflex latency using electrical stimulation of the dorsal nerve of the clitoris and recording muscle activity in the perineum
    - Pudendal nerve distal motor latency using the St. Mark's Stimulator
    - Pain relief following decompression of the nerve in Alcock's canal
    - Diagnostic nerve block
    - MRI

MAJOR OUTCOMES CONSIDERED

Not stated

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Hand-searches of Published Literature (Secondary Sources)
Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

A structured literature search was performed but this search was limited to randomized controlled trials and meta-analyses, covering at least the past three years, or up until the date of the latest text update if this exceeds the three-year period. Other excellent sources to include were other high-level evidence, Cochrane review and available high-quality guidelines produced by other expert groups or organizations. If there were no high-level data available, the only option was to include lower-level data. The choice of literature was guided by the expertise and knowledge of the Guidelines Working Group.

NUMBER OF SOURCE DOCUMENTS

Not stated

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Weighting According to a Rating Scheme (Scheme Given)

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Levels of Evidence

1a Evidence obtained from meta-analysis of randomized trials

1b Evidence obtained from at least one randomized trial

2a Evidence obtained from one well-designed controlled study without randomization

2b Evidence obtained from at least one other type of well-designed quasi-experimental study

3 Evidence obtained from well-designed non-experimental studies, such as comparative studies, correlation studies and case reports

4 Evidence obtained from expert committee reports or opinions or clinical experience of respected authorities

METHODS USED TO ANALYZE THE EVIDENCE

Systematic Review

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Not stated

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Expert Consensus

DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

- The first step in the European Association of Urology (EAU) guidelines procedure is to define the main topic.
- The second step is to establish a working group. The working groups comprise about 4 to 8 members, from several countries. Most of the working group members are academic urologists with a special interest in the topic. Specialists from other medical fields (pain medicine, psychology, radiotherapy, oncology, gynaecology, anaesthesiology, etc.) are included as full members of the working groups as needed. In general, general practitioners or patient representatives are not part of the working groups. Each member is appointed for a four-year period, renewable once. A chairman leads each group.
- The third step is to collect and evaluate the underlying evidence from the published literature.
- The fourth step is to structure and present the information. All main recommendations are summarized in boxes and the strength of the recommendation is clearly marked in three grades (A-C), depending on the evidence source upon which the recommendation is based. Every possible effort is made to make the linkage between the level of evidence and grade of recommendation as transparent as possible.

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Grades of Recommendation

A. Based on clinical studies of good quality and consistency addressing the specific recommendations and including at least one randomized trial
B. Based on well-conducted clinical studies, but without randomized clinical studies
C. Made despite the absence of directly applicable clinical studies of good quality

COST ANALYSIS

A formal cost analysis was not performed and published cost analyses were not reviewed.

METHOD OF GUIDELINE VALIDATION

Internal Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

The Appraisal of Guidelines for Research and Evaluation (AGREE) instrument was used to analyse and assess a range of specific attributes contributing to the validity of a specific clinical guideline. The AGREE instrument, to be used by two to four appraisers, was developed by the AGREE collaboration (www.agreecollaboration.org) using referenced sources for the evaluation of specific guidelines. (See the "Availability of Companion Documents" field for further methodology information).

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

Introduction

It is clearly important for the patient to have been thoroughly examined by a urologist or gynaecologist and local pelvic pathology excluded. Once a structural cause has been eliminated, a neurological opinion is often sought, with the prime aim of the neurologist being to exclude any form of conus or sacral root pathology. Magnetic resonance imaging (MRI) is the investigation of choice to show both neural tissue and surrounding structures.

If all examinations and investigations fail to reveal an abnormality, the diagnosis is likely to be one of the focal pain syndromes. These are persistent or recurrent or episodic pains referred to specific pelvic organs in the proven absence of infection, malignancy or other obvious pathology.

Pudendal Nerve Entrapment

Chronic compression of the pudendal nerve in the ischiorectal fossa may result in a perineal pain located either anteriorly in the vagina or vulval region, or posteriorly in the anorectal region. The International Continence Society (ICS) has used the following definition, 'perineal pain is felt: in the female, between the posterior fourchette (posterior lip of the introitus) and the anus, and in the male, between the scrotum and the anus'.

The pain may include unpleasant sensations of numbness or a burning sensation, and may be exacerbated by sitting and relieved by standing. Neurological examination of the perineum is often normal. If tested, the sacral reflexes are often present and anal sphincter tone is normal. Neurophysiological examination is said to be helpful is some cases; sacral reflex latency (using electrical stimulation of the dorsal nerve of the clitoris and recording muscle activity in the perineum) and the pudendal nerve distal motor latency using the St. Mark's Stimulator has been recommended. These investigations require specialist neurophysiological expertise and may be normal in the absence of clinically proven sensory changes.

Pudendal nerve neuropathy is likely to be a probable diagnosis if the pain is unilateral, has a burning quality and is exacerbated by unilateral rectal palpation of the ischial spine, with delayed pudendal motor latency on that side only. However, such cases account for only a small proportion of all those presenting with perineal pain. Proof of diagnosis rests on pain relief following local anaesthetic nerve blocks or decompression of the nerve in Alcock's canal, but long term pain relief is rarely achieved. The value of the clinical neurophysiological investigations is debatable; some centres in Europe claim that the investigations have great sensitivity, while other centres, which also have a specialized interest in pelvic floor neurophysiology, have not identified any cases. Further information may be gained by differential diagnostic nerve block or MRI investigation.

Other Neurogenic Conditions

Other pelvic floor clinical neurophysiological investigations are more helpful in identifying changes of denervation and re-innervation. Lesions causing such disorders are usually associated with bladder and/or sexual dysfunction rather than isolated urogenital pain.

CLINICAL ALGORITHM(S)

None provided

EVIDENCE SUPPORTING THE RECOMMENDATIONS

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The type of supporting evidence is not specifically stated for each recommendation.

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

Accurate diagnosis of pudendal nerve entrapment or other neurogenic conditions causing perineal pain

POTENTIAL HARMS

Not stated

QUALIFYING STATEMENTS

QUALIFYING STATEMENTS

- The European Association of Urology (EAU) believes that producing validated best practice in the field of urology is a very powerful and efficient tool in improving patient care. It is, however, the expertise of the clinician which should determine the needs of their patients. Individual patients may require individualized approaches which take into account all circumstances and treatment decisions often have to be made on a case-by-case basis.
- There are some very clear limitations on the use of the EAU Guidelines. These guidelines are specifically aimed at helping the practising urologist and will thus be of limited use to other health care providers or third party payers. These are limitations which we have accepted, given that the aim is to cover all of Europe and that such non-clinical questions are best covered locally. Another limitation is that the texts have no medico-legal status, nor are they intended to be used as such.
- The purpose of this text is not to be proscriptive in the way a clinician should treat a patient but rather to provide access to the best contemporaneous consensus view on the most appropriate management currently available. EAU guidelines are not meant to be legal documents but are produced with the ultimate aim to help urologists with their day-to-day practice.

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

The European Association of Urology (EAU) Guidelines long version (containing all 19 guidelines) is reprinted annually in one book. Each text is dated. This means that if the latest edition of the book is read, one will know that this is the most updated version available. The same text is also made available on a CD (with hyperlinks to PubMed for most references) and posted on the EAU websites Uroweb and Urosource (www.uroweb.org/professional-resources/guidelines/ & http://www.urosource.com/diseases/).

Condensed pocket versions, containing mainly flow-charts and summaries, are also printed annually. All of these publications are distributed free of charge to all (more than 10,000) members of the Association. Abridged versions of the guidelines are published in European Urology as original papers. Furthermore, many important websites list links to the relevant EAU guidelines sections on the association websites and all, or individual, guidelines have been translated to some 15 languages.

IMPLEMENTATION TOOLS

Pocket Guide/Reference Cards

For information about availability, see the "Availability of Companion Documents" and "Patient Resources" fields below.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Living with Illness

IOM DOMAIN

Effectiveness
Patient-centeredness

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

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ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

2008 Mar

GUIDELINE DEVELOPER(S)

European Association of Urology - Medical Specialty Society

SOURCE(S) OF FUNDING

European Association of Urology

GUIDELINE COMMITTEE

Not stated

COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

Primary Authors: M. Fall (*Chair*); A.P. Baranowski; S. Elneil; D. Engeler; J. Hughes; E.J. Messelink; F. Oberpenning; A.C. de C. Williams

FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

All members of the Chronic Pelvic Pain guidelines writing panel have provided disclosure statements on all relationships that they have and that might be perceived as a potential source of conflict of interest. This information is kept on file in the European Association of Urology Central Office database. This guideline document was developed with the financial support of the European Association of Urology (EAU). No external sources of funding and support have been involved. The EAU is a non-profit organisation and funding is limited to administrative assistance, travel, and meeting expenses. No honoraria or other reimbursements have been provided.

GUIDELINE STATUS

This is the current release of the guideline.

GUIDELINE AVAILABILITY

Electronic copies: Available in Portable Document Format (PDF) from the European Association of Urology Web site.

Print copies: Available from the European Association of Urology, PO Box 30016, NL-6803, AA ARNHEM, The Netherlands.

AVAILABILITY OF COMPANION DOCUMENTS

The following are available:

- EAU guidelines office template. Arnhem, The Netherlands: European Association of Urology (EAU); 2007. 4 p.
- The European Association of Urology (EAU) guidelines methodology: a critical evaluation. Arnhem, The Netherlands: European Association of Urology (EAU); 18 p.

The following is also available:

- Guidelines on chronic pelvic pain. 2005, Ultra short pocket guidelines. Arnhem, The Netherlands: European Association of Urology (EAU); 2008 Mar. 18 p.

Print copies: Available from the European Association of Urology, PO Box 30016, NL-6803, AA ARNHEM, The Netherlands.

PATIENT RESOURCES

None available

NGC STATUS

This NGC summary was completed by ECRI Institute on December 30, 2008. The information was verified by the guideline developer on February 27, 2009.

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